

**State of Wisconsin Employees
Underwritten by UnitedHealthcare Insurance Company**

BENEFITS AT A SPECTERA PARTICIPATING PROVIDER

Spectera's Vision Care Program provides affordable, quality vision care nationwide. Through Spectera's provider network you will receive a complete eye examination, as well as materials (if needed).

Carefully review the summary of your new Vision Care Program. Please, don't take chances with your most precious possession – the gift of sight. Take advantage of this very important benefit.

When using a Network Provider, enrolled participants and eligible dependents are eligible for the following:	
COMPREHENSIVE VISION EXAM (Once Every 12 Months)	A comprehensive vision examination, provided by a network optometrist or ophthalmologist, is 100% covered after a \$10 exam copay, once every 12 months.
PAIR OF LENSES (for glasses) (Once Every 12 Months) ➤ Standard single vision ➤ Standard lined bifocal ➤ Standard lined trifocal ➤ Standard lenticular	If prescribed, a pair of single vision or standard multi-focal lenses are 100% covered, after a \$25 materials copay, once every 12 months. Lens Options - Should you choose patient options not covered by the program such as progressive lenses, polycarbonate lenses, tints, UV, and anti-reflective coating, you may be able to purchase these options at a discount. Standard scratch coating is covered-in-full.
FRAMES (Once Every 24 Months) ➤ Selection frame ➤ Non-Selection frame	Your choice of Spectera selection frames is 100% covered, after a \$25 material copay, once every 24 months. If you select frames from outside the Spectera selection, you will be given a \$50.00 wholesale frame allowance at our private practice providers or a \$120.00 retail frame allowance at our retail optical providers. Only one \$25 material copay will be applied if the lenses and frames are purchased during the same benefit year.
CONTACT LENSES (Once Every 12 Months) ➤ Selection contact lenses ➤ Non-Selection contact lenses	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after a \$25 copay once every 12 months) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to 4 boxes (depending on prescription) are included when obtained from a network provider during one visit. It is important to note that Spectera's covered-in-full contact lenses may vary by provider. A \$105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera's covered-in-full contacts and for contacts at WalMart (\$25 materials copay is not assessed). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection. Please note: To receive the full \$105 allowance, you must receive your exam, fitting, and evaluation at the same provider.
REFRACTIVE EYE SURGERY:	Spectera participants receive access to discounted refractive eye surgery procedures from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at https://www.spectera.com/visionLaser.html .

BENEFITS AT AN OUT-OF-NETWORK PROVIDER

If you choose to use a non-network provider, you will be reimbursed up to:

<u>SERVICE</u>	<u>AMOUNT</u>	<u>SERVICE</u>	<u>AMOUNT</u>
Exam		Frames	\$45
Optometrist	\$40		
Ophthalmologist	\$40	Contact Lenses (<i>in lieu of spectacle lenses and frames</i>)	
Lenses (Pair)		Medically Necessary*	\$210
Single Vision	\$40	Elective	\$105
Bifocal	\$60		
Trifocal	\$80		
Lenticular	\$80		

* Medically Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: following cataract surgery, to correct extreme vision problems that cannot be corrected with spectacle lenses, with certain conditions of anisometropia, and with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.

If you choose a **non-network provider**, send your itemized receipts, with the primary-insured's Social Security number and the patient's name and date of birth, to:

**Spectera Claims Department
P. O. Box 26618
Baltimore, MD 21207-6618**

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

Spectera will reimburse you according to the schedule shown above.

Participating provider (Network) – provider copays and non-covered patient options are paid to participating provider by program participant.

Non-network provider (Out-of-Network) – participant pays full fee to the provider and Spectera reimburses the member for services rendered up to maximum allowance. All receipts must be submitted at the same time. Copays do not apply to out-of-network benefits.

Important Points to Remember:

- Always identify yourself as a Spectera member when making your appointment. This will assist your provider in obtaining a claim authorization prior to your visit.
- Benefits are available every 12 or 24 months (depending on the benefit frequency) based on last date of service.
- Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
- Benefits for contact lenses are in lieu of a lens and frame. Your provider will help you determine which contact lenses are covered under your benefit. Contacts should be purchased for the year during one visit.
- Your \$105 contact lens allowance is applied to the fitting fee and evaluation as well as the purchase of contact lenses (for instance, contacts at WalMart). For example, if the fitting fee and evaluation is \$33, you will have \$72 towards the purchase of contact lenses. The allowance may be separated at some retail locations between the examining physician and the optical store. Some out-of-pocket expense may result from the purchase of contacts not included in the Spectera selection, such as torics, gas permeables and bifocal contact lenses.
- Patient options such as UV coating, progressive lenses, etc., are not covered in full but are provided to Spectera members at a savings below usual and customary charges.

CHOICE AND ACCESS OF VISION CARE PROVIDERS

With Spectera, you are able to choose from network private practice providers and retail optical providers. If you would like to identify a network provider prior to enrolling in or using the Spectera Vision Care Program, visit Spectera's Web site at www.spectera.com and select "Future Member" on the right hand side of the screen. Or call Spectera's Provider Locator Service at 1-800-839-3242 and follow the voice prompts:

- Select language desired.
- Select Option 1 "Open Enrollment" to locate doctors in your area.
- Enter the ZIP code for the area you wish to check.
- After each entry, the system will repeat what you have entered and ask that you "Press 1" if correct, or "Press 2" if incorrect
- The system will then identify up to three network providers in the requested ZIP code's area
- If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2".

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a Spectera participant.

AFFORDABLE COVERAGE

Spectera's vision benefit is very affordable. The monthly premiums are:

Employee Only:	\$ 5.40 per month
Employee + Spouse:	\$10.50 per month
Employee + Child(ren):	\$11.00 per month
Employee + Family:	\$16.50 per month

Please retain this Benefit Summary for future reference. Customer Service is available toll free at 1-800-638-3120 Monday through Friday from 7:30 am to 7:00 pm and Saturday from 8:00 am to 4:00 pm.

The following services and materials are excluded from coverage under the Policy:

1. Post cataract spectacle lenses,
2. Non-prescription items,
3. Medical or surgical treatment for eye disease, that requires the services of a physician,
4. Worker's Compensation services or materials,
5. Services or materials that the patient obtains without cost from any governmental organization or program
6. Services or materials that are not specifically covered by the Policy,
7. Plain sunglasses,
8. Replacement or repair of lenses and/or frames that have been lost or broken,
9. Cosmetic extras, except as stated in the Policy's Table of Benefits.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.

This insurance plan has been authorized by the Group Insurance (Board) for the purpose of permitting premium collection through payroll deductions under authority granted by Wis. Stat. § 40.03 (6) (b) and pursuant to Wis. Stat. §20.921 (1) (a) 3. The criteria the Board uses involves meeting several requirements which include, but are not limited to: documentation of financial stability, demonstration of a reasonable ratio of claims paid to the premium level, authority to conduct business in the State of Wisconsin, agreeing to conditions for the rate-making process and other administrative conditions. Employee Trust Funds (ETF) staff and the Board's actuary review proposals for participation prior to Board approval. However, the Board does not require competitive bids nor a benefit comparison with similar products from other vendors. **Authorization for payroll deduction should not be construed as an endorsement of this plan by either the Group Insurance Board or the Department of Employee Trust Funds.** Premiums will be deducted from your paycheck on a pre-tax basis automatically, unless you file an Employee Reimbursement Accounts (ERA) Program Automatic Premium Conversion Waiver form (ET-2340) with your payroll office when you sign up for this benefit. Remember that the copays and other expenses for vision care that are not paid for by this benefit plan may be reimbursed through your ERA Medical Reimbursement Account.